# Eli's Hospice Insider

## Compliance: Avoid These 6 Fraud Pitfalls CMS Is Looking For

**How many diagnoses you include on your claims could single you out for scrutiny.**

Medicare's proposed rule for 2017 hospice payment may contain some big changes such as new quality measures and a new OASIS-like assessment tool on the horizon. But the most difficult challenge is likely to be the scrutiny hospices will be under for regulatory and compliance hot spots, the **Centers for Medicare & Medicaid Services** indicates.

**Good news:** Some of the big hospice data points CMS and its contractors are tracking have gone down, points out **Judi Lund Person** with the **National Hospice & Palliative Care Organization**. For example, these figures have all decreased: percentage of claims with only one diagnosis; nonhospice spending for hospice patients; Part D spending on drugs for hospice patients; and live discharges (see specific stats, this page).

**Bad news:** But it appears to be too little, too late. CMS spends a big chunk of the proposed rule outlining its concerns with various areas and warning hospices that it will be monitoring the data and planning related action.

"The greatest risk for hospice agencies ... is not necessarily one of the proposals in the rule, but rather the warnings from CMS that it suspects certain hospice providers of engaging in widespread fraudulent activity," says RN **Beth Noyce** with **Noyce Consulting** in Salt Lake City.

**Watch out:** Providers whose data sticks out in CMS's areas of concern will most likely "eventually face provider-specific reviews," Noyce expects. "My concern is that much hospice clinical documentation may not pass muster under medical review."

Check out the areas that CMS highlights as fraud and abuse hot spots in its proposed hospice payment rule that was published in the April 28 Federal Register:

**Hot Spot #1: Diagnoses**

If you're still including only one or two diagnoses on your patients' claims, you're likely in for more scrutiny ahead. The percentage of claims with more than one diagnosis has gone up lately, but it's still a sore spot.

Providers must "report all diagnoses on the hospice claim for the terminal illness and related conditions, including those that affect the care and clinical management for the beneficiary," CMS says in the proposed rule. "Hospices will report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, effective October 1, 2015," the agency reminds.

Providers often tell Noyce that "we've always put just one diagnosis on the hospice claims," she tells **Eli**. That's not going to cut it going forward, and could land you in the feds' crosshairs.

And as for the specific diagnoses themselves, CMS reiterates its previously voiced suspicion of neurological conditions and hospice eligibility. Neuro diagnoses including "Alzheimer's disease, other related dementias, and Parkinson's disease ... are associated with longer disease trajectories, progressive loss of functional and cognitive abilities, and more difficult prognostication," according to the rule.

**Bottom line:** The data CMS includes in the report "suggest that some hospices may be using the Medicare Hospice

program inappropriately as a long-term care ('custodial') benefit rather than an end of life benefit for terminal beneficiaries," CMS says. "There is a concern that hospices may be admitting beneficiaries who do not legitimately meet hospice eligibility criteria."

**Hot Spot #2: Drugs**

CMS also circles back to its concern over Medicare double-paying for hospice patients' medications. "Hospices are required to cover drugs for the palliation and management of the terminal prognosis; we remain concerned that common palliative and other disease-specific drugs for hospice beneficiaries are being covered and paid for through Part D," according to the rule. "Because hospices are required to provide a comprehensive range of services, including drugs, to Medicare beneficiaries under a hospice election, we believe that Medicare could be paying twice for drugs that are already covered under the hospice per diem payment by also paying for them under Part D."

**Usual suspects:** Common culprits for double payment include "analgesics (antiinflammatory, non-narcotic, and opioids), antianxiety agents, antiemetics, and laxatives," CMS notes. The agency also lists other drugs typically associated with patients' conditions in a chart in the proposed rule.

**Pitfalls:** Noyce says she often hears statements from providers like "now that the hospice drug billing thing has blown over, we went back to putting just one diagnosis on the claims," and "we go down the medication list and choose which ones we'll pay for and which ones we won't. Then the doctor signs it. That's how we show what's unrelated to the terminal illness for the claims." Those kinds of statements are going to get claims denied under scrutiny, Noyce warns.

**Hot Spot #3: Relatedness**

CMS doesn't spend a lot of space on relatedness to the terminal illness in the rule, but the diagnoses, drug, and non-hospice spending emphases go to the hot button topic. Even though non-hospice spending for hospice patients is down, recent analysis "seems to suggest unbundling of services that perhaps should have been provided and covered under the Medicare hospice benefit," the agency suggests in the rule.

**Remember:** "Hospices are required to provide virtually all the care that is needed by terminally ill patients," CMS says. "Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis, all conditions are considered to be related to the terminal prognosis and the responsibility of the hospice to address and treat."

CMS expects "'virtually all' care needed by the terminally ill individual would be provided by hospice, given the interrelatedness of body systems," the agency explains. "It would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life."

**Hot Spot #4: Long Stays**

The data CMS cites in the rule show that long stays correlate with a number of other red flags.

For example, "hospice patients with the longest length of stay had lower pre-hospice spending relative to hospice patients with shorter lengths of stay," CMS notes. They often have neuro diagnoses. Hospices who score high in one red flag category often score high in multiple areas. For example, "hospices in the highest decile, according to their level of non-hospice spending for patients in a hospice election, had live discharge rates and average lifetime lengths of stay that averaged 90 percent and 58 percent higher, respectively, than the hospices in [the] lowest decile," CMS notes.

**Target:** The **HHS Office of the Inspector General** "has raised concerns about the potential for hospices to target beneficiaries who have long lengths of stay or certain diagnoses because they may offer the hospices the greatest financial gain," CMS notes.

**Hot Spot #5: Live Discharges**

CMS continues to beat the drum on the potential abuse of live discharges. "Hospices may not discharge the patient at their discretion, even if the care may be costly or inconvenient for the hospice program," the rule stresses.

"We understand that the rate of live discharges should not be zero, given the uncertainties of prognostication and the ability of beneficiaries and their families to revoke the hospice election at any time," CMS acknowledges. But a high discharge rate often correlates with high rates in other red flag areas, and CMS plans to keep its eye on the problem.

**Hot Spot #6: Visits In Last Days of Life**

CMS also pursues its scrutiny of services offered at end of life, citing the recent Journal of American Medical Association article on the issue (see Eli's Hospice Insider, Vol. 9, No. 4). CMS's own data shows nearly half of patients didn't receive a skilled visit in the last week of life (see stats, cover story).

"We are concerned that many beneficiaries are not receiving skilled visits during the last few days of life," CMS says in the rule. "We believe it is important to assure that beneficiaries and their families and caregivers are, in fact, receiving the level of care necessary during critical periods such as the very end of life."

**Steps taken:** The new Service Intensity Add-on payments included in hospice payment reform that took effect Jan. 1 will hopefully help with this issue, CMS says. So will the newly proposed quality measure for 2017, "Hospice Visits when Death is Imminent" (see details of that measure in Eli's Hospice Insider, Vol. 9, No. 6).

Note: You can submit comments on the proposed rule until June 20 via www.regulations.gov/#!submitComment;D=CMS-2016-0058-0002.